Guidelines for Submitting Corrected EDI Claims
11/1/2006

1. If the original claim status is "DENIED" due to DMH RULES or CICS violations, what is the proper way to send in the corrected claim?

   Send in as an Original (new) claim with a unique submitter ClaimID.

2. If the original claim status is "DENIED" due to "FIN ADJ" at the state level, what is the proper way to send in a corrected claim?

   There are several possible scenarios depending upon how you wish to correct the claim.

   A. If you **are not** changing the local plan but wish to send a corrected claim back to the state, then simply send in a Replacement claim.

   B. If you **are** changing the local plan and sending the corrected claim back to the state, you must send in a Void AND a Replacement claim.* (Voiding a denied claim will only be possible when the I.S. 2.0 is implemented.)

   C. If you **are not** changing the local plan and **are not** planning to send a corrected claim to the state (e.g., the client is no longer Medi-Cal eligible), you may choose to do nothing. The County may pay the provider from the local plan indicated on the original claim. (However, when I.S. 2.0 is implemented, it might be best practice to send a Void for the original claim and send in a Replacement claim. This may be less confusing in reconciling your claims since you will not have to deal with getting paid on a "denied" claim.)

   Please also see Note 1 below for further details.

3. If the original claim status is "PENDING" and we need to fix it for some reason, what type of claim(s) do we send?

   First send in a Void, then send in the corrected claim as Original (new).

4. If the original claim status is "PENDING ADJUDICATION" and we need to fix it for some reason, what type of claim(s) do we send?

   First send in a Void, then send in the corrected claim as Original (new). In IS 2.0, we will not see this status anymore. Auto adjudication will take place.

5. If the original claim status is "FORWARDED" and we need to fix it for some reason, what type of claim(s) do we send? What if the status in the EOB is "S" for suspended?

   First send in a Void, then send in the corrected claim as Original (new).

   If the status in the EOB is "S" (Suspended), then wait until it is denied by the State or work with the ECR. Please see Note 2 below for ECR details.

6. If the original claim status is "APPROVED" and we need to fix it for some reason, what type of claim(s) do we send?

   First send in a Void, then send in the corrected claim as Original (new).

*EDI submitters **must void** the first claim if they want to send in a replacement claim with another local plan. If they do not void the first claim and send in a replacement claim with a different local plan, it would be considered as a duplicate and DMH would not be able to catch it. The same claim would be billed twice, hence would be paid twice from two different local plans and/or MC (if MC approves the replacement claim). If a claim is approved by the State, then it would be paid out of the MC allocation; DMH would apply the FMAP (Federal Medical Assistance Percentage) as applicable depending on the type of MC (EPSDT or not).

Note 1:

When the IS automatically denies a claim due to a Medi-Cal denial, this sets of a status of 'Denied' in the IS and at this time the provider can send in a replacement (claim frequency 7) claim. If the provider does not include Medi-Cal on the subsequent replacement claim – the claim will not go to Medi-Cal.

Here is the step by step detail of the process:

1. Provider sends Claim to IS with Medi-Cal as a payer
2. Claim passes IS Rules and MHMIS edits
3. IS sends claim to Medi-Cal
4. Medi-Cal returns denied 835 to IS
5. IS automatically denies claim since Medi-Cal denies
6. IS sends denied 835 to provider
7. Provider can respond as in scenarios 2A, 2B, or 2C noted above. Note that the IS will only send the claim to Medi-Cal, if Medi-Cal is included in the replacement claim.

Note 2:

The following is a repetition of a memo sent by:

LOS ANGELES COUNTY – DEPARTMENT OF MENTAL HEALTH / REVENUE MANAGEMENT DIVISION

The Revenue Management Division (RMD) has been working with the State Department of Mental Health (SDMH) and the Chief Information Office Bureau in order to re-implement the Medi-Cal Error Correction Report (ECR). The ECR will allow for Medi-Cal claims to be corrected while they are still at the State. RMD was notified by SDMH that the "Suspense" file is ready to be re-implemented during the week of March 13, 2006. This means that RMD needs an ECR Liaison for every provider.

Attached is an *"ECR Provider Information Sheet"* which should be completed by the Program Manager for each Directly Operated Program. If RMD does not receive an "*ECR Provider Information Sheet"*, the ECRs will be mailed out to the address listed in the Provider Directory. This may result in the ECR package being misdirected or even lost. Should this occur, there may be a possibility of lost revenue.

If you have any questions or require further information, please do not hesitate to contact RMD at (213) 639-6326 or via e-mail at RevenueManagement@lacdmh.org.